SELF-INSURER REQUEST
TO ADD OR DELETE SUBSIDIARY/AFFILIATE

Michigan Department of Consumer & Industry Services
Bureau of Workers' Compensation
Self-Insured Programs
7150 Harris Drive (48913)
PO Box 30016
Lansing, Michigan 48909

Employer Record	**OFFICE USE ONLY** **Approved/Denied** **Effective**
_____	_____

Authority: Workers' Disability Compensation Act of 1969, as amended **Completion:** Mandatory **Penalty:** Denial/Termination of Self-Insured Status	**The Department of Consumer & Industry Services will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, height, weight, or political belief.**

To add or delete a subsidiary or affiliate in a current self-insured program, complete this form and submit it to the address noted above.

Name of Current Self-Insurer		Federal I D #	

To add or delete, complete this section

1. This is an ☐ Addition ☐ Deletion

2. Subsidiary/Affiliate

Name		Federal ID #	
Address	City	State	Zip Code

3. Michigan Locations

Name		Federal ID #	
Address	City	State	Zip Code

4. Effective date requested

5 Reason for addition/deletion (If sold, to whom)

_____

_____

***For additions only**, complete this section. Also, attach financial statements including the new subsidiary/affiliate.*

6. Indicate affiliation: % of ownership by current self-insurer ____ %

   Common shareholder with current self-insurer ☐ Yes ☐ No

7. Will claims payment guaranty be furnished? ☐ Yes ☐ No

8. The additional subsidiary/affiliate business was chartered under the laws of the state of _____ on _____.

9. Total number of employees of additional subsidiary/affiliate ____ In Michigan ____

10. Amount of Michigan payroll for the current year for additional subsidiary/affiliate $ ____

11. If aggregate excess insurance is maintained, estimate increase in retention $ ____

AUTHORIZED SIGNATURE	TITLE	DATE